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ABSTRACT

Investigating the role of the social worker in rural Community Mental Health Centers (CMHC), 20 CMHC and 595 community mental health workers were surveyed, including 140 social workers distributed in inner city (47), urban (9), urban-mixed (38), rural-mixed (29), and all-rural (17) catchment areas. Analyzed by center type and worker discipline, responses were compared in terms of the following variables: (1) Community Mental Health Ideology (endorsement); (2) Organizational Perception of CMHC (medical facility mode vs social service mode); (3) Professionalism; (4) CMHC Role Activism (role behavior response to 18 vignettes); (5) Personal-Professional Role Activism; (6) Role Discrepancy (CMHC's expectations vs social workers'); (7) Two Role Exclusion (perceived scope vs limitations). Findings indicated: (1) inner city and rural social workers most highly endorse CMHC ideology; (2) rural social workers, more than any others, view their CMHC as a social agency organization; (3) rural social workers, in contrast to others, perceive their organizations as expecting greater activism in their roles; (4) inner city social workers are most activist in role definition, while rural workers occupy a more modal position; (5) rural social workers perceive their CMHC's as expecting the fewest areas of community life to be excluded. (JC)

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THE SOCIAL WORKER IN THE RURAL COMMUNITY MENTAL HEALTH CENTER

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INTRODUCTION

With community mental health a decade old, attempts at the assessment of its effects and nature seem in order. The concept of community mental health has been embodied in an organizational form known as the community mental health center. Federally supported by the Community Mental Health Center Act, almost 600 centers have been established throughout the United States and 500 are in operation. With the mandate for community mental health, these centers are intended to be unique and innovative by extending their activities beyond their walls into the community proper. No longer is adequate psychiatric care to be the province of the urban affluent.

In prior research (Jones et.al., 1974), we have documented the fact that the general "health services imbalance" in rural areas also extends to mental health. Relatively few CMHC's have been established in rural areas, and those that have been established are newer, have a more precarious financial base, and are forced to rely more heavily on part-time and paraprofessional staff. Virtually all rural CMHC's operate in catchment areas that are also federally designated poverty areas (also see USDHEW, 1973; USDHEW, 1974; USDA, 1970; Kraenzel and MacDonald, 1971).

Prior research also has shown, however, that all-rural CMHC's and their staffs have developed unusual patterns of community involvement, non-medical orientations to their work, and uniquely strong community mental health ideologies. In these findings we concurred with Wilson (1971) who concluded that rural CMHC's and workers have developed a highly efficient mental health delivery service, and one that could serve as a model for other areas.

Among the professionals staffing those rural centers, the social worker plays a crucial role. The social worker is by training and perspective

a prime candidate for being the moving force in inserting "community" into community mental health.

In this research, we will focus on several related themes: rural mental health and social problems, characteristics of rural community mental health centers, the characteristics of social workers, social workers as community mental health workers, and -- as a convergence of these several themes -- social workers in rural community mental health centers.

SOCIAL WORKERS IN PROFILE

There are data that indicate that the social workers are different from others who supply mental health services. We refer to a recent definitive study by Henry et.al. (1971), in which social workers are compared on a number of social and professional dimensions to other mental health professionals. Social workers stand out as substantially and consistently different when compared to psychoanalysts, psychiatrists and psychologists in orientation toward their occupations, religiousity, political participation and social origins.[1]

Social workers were more frequently recruited from the social sciences and less frequently from the physical or biological sciences than their counterparts. They were mostly highly influenced to select their job because of the intrinsic nature of the job, the field work aspect of the job and were much the highest in selecting their profession because it allowed the social worker to recognize his/her potential for ability and pleasure in his/her profession. On the other hand, the social workers were the lowest among the professions to choose the job for intellectual

[1]In this research a survey of 6629 mental health professionals was augmented by in-depth interviews of an additional 179 mental health professionals; both samples were from the Chicago, Los Angeles and New York metropolitan areas.

stimulation and for purposes of understanding people. In accounting for career choice, the social workers were significantly higher than their colleagues in other disciplines in their motives to achieve affiliation with others, to help people and to help and understand society.

In the political sphere, social workers constitute the most politically liberal of the mental health professionals. Additionally, they were also the least conservative. Henry noted:

> The explanation . . . may lie in the fact that psychiatric social work is the most overtly political of all mental health professions. This is, psychiatric social work emerged from the social reform tradition of general social work and still has strong ties to welfare and community service organizations. Indeed, psychiatric social workers are frequently employed in action oriented programs and community organizations. (1971, p. 4)

Finally, in origins, social workers are also different. To a greater extent than the other professions, they trace their origins to the U.S. and other English speaking nations. They come from lower social class origins than do their psychoanalytic, psychiatric and psychological counterparts. Moreover, they more frequently come from rural backgrounds.

In sum, social workers differed from other mental health professionals in ways that led us to predict their special functioning and characteristics within community mental health centers. There seems to be convergence with the mandate of the community mental health centers and the proclivities of social workers. This is summed up by David Hallowitz (1972), who maintains:

> Social Action and social reform can be responsibly fulfilled by those social workers, case workers included, who have the interest and competency to specialize in social planning and social action . . . . They possess the ability to understand the dynamics of the individual's functioning in group situations and an orientation that probably can be transposed into social-planning and social-action activities. (p. 75)

INTRODUCTION TO COMMUNITY MENTAL HEALTH WORKER RESEARCH

These background materials provide an introduction to our concerns about the characteristics of community mental health centers in rural

settings and the nature of the professional functioning of social workers within them.

Our research on community mental health worker roles allows us to address ourselves more directly to the question of the characteristics of the social worker in rural community mental health centers. Five hundred ninety-five community mental health workers, 140 of them social workers, were surveyed in twenty CMHC's. These workers were employed in four Inner City centers, two Urban centers, six Urban-Mixed centers, five Rural-Mixed centers, and three Rural centers. Seventeen of the 140 social workers (12.2 per cent) were employed in CMHC's serving All-Rural catchment areas, while the balance were distributed in the following fashion: 47 (33.6 per cent) in Inner City, nine (6.4 per cent) in Urban, 38 (27.1 per cent) in Urban-Mixed, and 29 (20.7 per cent) in Rural-Mixed. The centers for study were selected to represent combinations of organizational and catchment area variables common to the population of CMHC's.

Worker survey responses were analyzed by type of center in which they were employed and their discipline (psychiatrist, social worker, paraprofessional, etc.) so that the characteristics of social workers in rural centers could be examined in relation to social workers in other CMHC settings and types of workers in various CMHC settings. Several variables, pertinent to the nature of community mental health and the functioning of centers were selected:

Community Mental Health Ideology, the extent to which the worker endorsed a belief system containing the tenents of the ideology which was the raison d'etre for the community mental health movement, was measured through the Baker-Schulberg CMHI scale. This summated measure has been used in several studies and is a reliable, well-validated measure. (See

Baker and Schulberg, 1967; Howard and Baker, 1971; Langston, 1970; Wagenfeld et.al., 1974.)

Organizational Perception of CMHC was measured by contrasting the medical facility mode of CMHC organization with the social service agency mode. Each worker was asked to place his/her center on a ten point continuum with medical facility at one end (10) and social service agency at the other (1).

Professionalism was measured by a version of the Billingsley Professionalism Scale (Billingsley, 1964). Using the endorsement of "stated professional standards" as an index of professionalism, the worker was asked whether he or she would opt for these standards when they clashed with, respectively, client needs, agency policy and community standards. Therefore, three separate indices of professionalism were available.

Community Mental Health Center Role Activism was calculated by presenting each worker with a set of eighteen community mental health vignettes illustrative of "typical" community situations they might encounter. To each vignette, the worker was asked to indicate which of a series of four role behaviors he/she felt the CMHC expected of him/her as a worker. The behaviors presented to the respondent were systematically varied in the extent to which they were activist. In other words, responses ranged from "traditional" activities such as consultation with caregivers or the giving of expert testimony to such "non-traditional" behaviors as helping to organize and participate in sit-ins, strikes, etc. Activism was seen as the willingness to change the communities or social structures as a solution to the mental health problem presented in the vignette. Each set of substantive responses were ranged from 1 (least activist) to 4 (most activist). The sum of the scores over the eighteen vignettes comprised this activism score.

Personal-Professional Role Activism was measured in exactly the same fashion except that the respondent was asked to select the preferred role behavior on the basis of his/her personal and professional preference.

Role Discrepancy was defined as the extent to which there was a difference between what the worker perceived of as CMHC expectations and his or her own personal proclivities.

Finally, Two Role Exclusion Scores were developed. For each vignette, the worker also had the option of selecting a response which indicated that the respondent thought the situation depicted in the vignette was irrelevant to the concerns of a community mental health worker and that avoidance or no role behavior was proper. This measured the perceived scope or extent of the worker's role. This revealed what the workers viewed as the appropriate domain of community mental health. The number of times this vignette response was selected by a worker in response to the vignettes when responding as he/she thought their center defined their role constituted the Community Mental Health Role Exclusion Score. The number of times this was selected from a personal-professional perspective constituted the Personal-Professional Role Exclusion Score.

FINDINGS

Our findings are presented in three parts. First, those findings about rural CMHC's not previously reported (Jones et.al., 1974) and summarized in the introduction of this paper. Second, those findings about social workers in our sample of CMHC's; and third, the findings about social workers in rural CMHC's.

(Table 1)

Table 1 presents the data about the role activism of community mental health center workers. We developed three measures of role activism:

organizational personal, and the discrepancy between the two. By a significant margin, staff at rural CMHC's perceived that their organizations expected the highest level of community role activism. In addition to perceiving high levels of organizational expectation for activism, rural CMHC staff had the highest level of agreement among themselves about these expectations.

Turning to the other side of the ledger -- person-professional activism free of organizational constraints -- rural CMHC staff were in the middle; with Inner City workers seeing themselves as most oriented toward role activism and Rural-Mixed as least so.

Perhaps the most important aspect of this variable of role activism is the extent which a discrepancy exists between what one perceives as organizational expectations and one's personal inclinations. It is important for perhaps no other reason than such discrepancy may be the locus of personal and organizational conflict. In this respect, rural CMHC staff are markedly less discrepant than their counterparts in other settings. This is true when looked at through one way ANOV and, with the exception of Rural-Mixed centers, significant differences are also noted between Rural and other centers in two-at-a-time comparisons via Student's t. The differences between Rural and Inner City CMHC's are most notable. In the latter case, high personal expectations coupled with relatively low organizational norms appear to engender a high discrepancy between the "real" and the "ideal." Not so with staff at Rural CMHC's. The fact that they are organizationally most activist and relatively activist on the personal plane leads to a high degree of role convergence.

(Table 2)

We were also concerned with the question of domain: which of the

areas of community functioning are considered to be outside the purview of the CMHC worker (See Table 2). Again, the rural CMHC's differed significantly from their other geographic counterparts. Organizationally, they see the fewest areas of community life as being irrelevant for CMHC intervention or involvement.

As one might expect, the same picture, on a more intensified scale, obtains with regard to personal/professional views of domains: rural CMHC staff see, on the average, less than two out of a possible eighteen areas as being "off limits," far fewer than their counterparts in CMHC's in other locales.

(Table 3)

An examination of geographic differences in endorsement of the ideology of community mental health (Table 3) reveals no statistically significant differences.

(Table 4)

When queried on their perception of the position of their CMHC on a medical facility-social agency continuum (Table 4), staff at rural CMHC's were markedly more likely to view the center as closer to a social agency. In this sense, rural CMHC staff are divergent from their colleagues in other geographic settings.

(Table 5)

Finally, when we examine the several dimensions of professionalism (Table 5), staff at Inner City CMHC's were most client oriented, with Rural staff occupying something of a middle ground. The same general situation obtained with respect to community standards. No significant differences were observed in agency expectations.

In sum, it seems fair to assert that, in their perception of role and domain, staff in rural CMHC's are different. Workers in rural CMHC's were markedly more activist than their colleagues in the area of organizational role activism. In personal-professional activism, they occupied a middle ground. Importantly, the net result of this is that rural CMHC workers appeared to be least subject to a discrepancy between "real" (i.e., organizational) and "ideal" (personal) expectations. The structural and service delivery differences seem to stem from a variety of sources: the poverty and low tax base of their catchment areas, a general paucity of social and health services, and a heavy reliance on part-time and paraprofessional staff. Additionally, as we have seen, rural CMHC staff differ in many respects from the staff of other kinds of centers. Given these differences, one can further suggest that the current -- urban based -- model of community mental health services may be inappropriate for rural needs.

A comment on the strong relationship between geographic composition of the catchment area and various dimensions of role perception and professionalism seems in order. The CMHC's (and their staff) serving all rural areas appear to be different. Those serving some rural constituency (i.e., Rural-Mixed) are not. In the absence of evidence, we may only speculate that when rural and non-rural areas are combined within a catchment area, the mode and content of service delivery of the CMHC fails to develop in the same fashion as the All-Rural CMHC. It is as if the response to unique rural needs does not materialize when any other competing demographic elements intercede. This would be consistent with the "rural populations last" proclivities noted in health and service resource distribution that has been generally noted in this country.

Two empirical questions remain to be answered in this section: 1) Are social workers -- as a group -- different from their colleagues in other professions in the CMHC, and 2) are social workers in rural CMHC's different from social workers in other settings?

(Table 6)

In a variety of ways, we have noted that social workers differ from their counterparts in the other helping professions. The data from our national study of community mental health worker roles extends these conclusions to the CMHC. In what way do they differ from their professional and paraprofessional counterparts in CMHC's? As already indicated, a number of attitudinal and role variables are available on which to make comparisons. When compared to the other major professional and paraprofessional groups in the CMHC's, the social workers displayed the highest endorsement of the ideology of community mental health (Table 6). Immediately behind social workers were psychologists. To a reader familiar with mental health, it should come as no surprise that psychiatrists showed the lowest endorsement of this ideology. Perhaps more surprising, in view of much of the rhetoric of the past decade, is the fact that paraprofessionals were among the lowest endorsers of the ideology of community mental health. The findings of a high social worker endorsement of the ideology is important for a number of reasons, and we will return to it in our next section.

(Table 7)

When our respondents ranked their CMHC on a social agency/medical facility continuum (Table 7), the perception of social workers was akin to that of psychiatrists and nurses in seeing it as a medical facility. Their similarity to other professionals, however, masks some important

differences that will become evident when we compare social workers in various geographic settings.

(Table 8)

The issues of "professionalism" and the striving of many occupations to become recognized as professions have certainly been important -- expecially for social work. How "professional" were our social workers relative to the other occupational groupings? Among the major occupational groups, social workers were the most client-oriented -- i.e., the "least professional" (Table 8). Not surprisingly, psychiatrists and nurses were most oriented toward adherence to professional standards. In general, when confronted with possible agency/profession, client/profession, and community/profession conflicts, social workers were less likely to opt for the professional response than were psychiatrists, psychologists, and nurses.

To put it in a different way: social workers -- as a group -- were more willing to violate or ignore professional standards, carry out agency policy, or be consonant with community expectations in order to meet the needs of clients.

(Table 9)

When we look at organizational perception of role activism in Table 9, one of the interesting findings was a lack of difference among the several professional groups. Social workers, along with their colleagues, tended to view the organizational expectation of appropriate behavior in a very uniform manner, suggesting a similarity of socialization.

A very different picture emerges, however, when our respondents were asked to respond to the same situations in terms of their own personal/professional proclivities -- free of organizational constraint. Here,

social workers emerged as defining the role of CMH worker in the most activist fashion of the major occupational groups in the CMHC's.

We have suggested that an important consideration in understanding the role orientations of community mental health workers was the degree to which there was a (role) discrepancy between organizational and personal courses of action in the same situation. Using this measure we found that social workers emerged as the most discrepant of the several occupational and professional groups in CMHC's. It would seem that this finding has important implications for program planning and staff morale.

(Table 10)

It is one thing to measure the relative degree of role activism with respect to organizational and personal expectations for a given situation. Here, one is measuring a gradient. It is quite another thing to ask: "Is a given situation or area of community functioning part or not part of the realm of community mental health?" This dichotomy furnishes us with a measure of the mental health workers' perceived extent of community mental health's domain. In other words, how much of the community is grist for community mental health's mill and how much is excluded? A comparison of the several professional groups in Table 10 revealed no significant differences among them on this "Exclusion Score." In fact, social workers were slightly higher in perceiving their organization as excluding certain areas from CMHC's purview.

When we turn to the personal side of the ledger, the picture changes dramatically: social workers tend to exclude significantly fewer areas of the community than their professional counterparts. Put another way, social workers see the domain of community mental health as very broad. Again, this suggests a role discrepancy of some magnitude between social

workers' personal/professional view of appropriate domain they think their CMHC's expect.

To sum up: our data suggest that social workers as a group are the "cutting edge" in endorsing the "community" aspect of community mental health. Their close peers are psychologists. At the other end of the continuum are the psychiatrists -- with a very low inclusion of the "community" element in community mental health. Suffice it to say, we can state that social workers are different.

To this point, we have suggested that role perceptions of staff in the Rural CMHC's differ from their more urban counterparts -- perhaps stemming from a unique blend of rural isolation, a paucity of social services and social service professionals, and a response to a series of unique health and social problems. We have also shown that social workers differ from their peers in community mental health in a number of important ways.

Blending the themes of Rural CMHC's and social workers leads to the question of whether social workers in Rural CMHC's differ from social workers in other settings. By looking at our sample of social workers separately, we ask the question whether social workers in one geographical setting differed from those in another.

(Table 11)

When we compared our social workers in the several geographic settings on the endorsement of the ideology of community mental health (see Table 11), we found a statistically significant relationship: both Inner City and Rural social workers were the strongest endorsers of the ideology. In fact, their scores were identical. They did differ, however, in degree of homogeneity: Rural social workers were considerably more homogeneous in their endorsement of community mental health ideology than their Inner City counterparts.

(Table 12)

When asked to characterize their CMHC's on a social service/medical continuum, social workers in Rural CMHC's (as reported in Table 12) were more likely -- by a significantly wide margin -- to see their centers as lying far down the social service agency end of the continuum (2.9 on a continuum where "10" was the medical model). Of interest is the fact that Inner City workers, of all social workers in our sample, saw their organizations as most like a medical facility. It appears to us that this differential organizational perception is quite important and we will take a closer look at its implications in the next section.

(Table 13)

While social workers were generally "less professional" and more client-oriented than psychiatrists, psychologists, and nurses (as seen in Table 13), within the social worker category, no significant differences were found by geographic area. In terms of client/professional and agency/professional conflict: workers in all settings were about equally likely to opt for the needs of the client or agency policy when these conflicted with professional standards. There was a slight or not statistically significant greater tendency to adhere to professional standards when these clashed with agency policy. However, when it comes to the violation of community expectations, social workers in Rural and Rural-Mixed areas exhibited a higher level of professionalism than their peers in Inner City, Urban, and Urban-Mixed CMHC's. In fact, Inner City social workers are "least professional" in this regard. Rural and Rural-Mixed social workers were the "most professional" with respect to the community. For practitioners in rural social work or students planning careers in this area, this would appear to be an important consideration.

(Table 14)

Turning to our several measures of social activism in Table 14, we found that our rural social workers perceived their organizations as expecting the highest degree of activism from them. Their Inner City counterparts were second. The other geographic settings were significantly below these two. In terms of personal/professional activism, Rural social workers were not outstanding in defining their roles in terms of personal/professional activism. Among social workers in the five types of CMHC settings, they ranked third in activism. Social workers, regardless of geographic setting, define the domain of their role similarly.

Most important, perhaps, is role discrepancy: to what extent is there a disjuncture between an individual's organizational and personal/professional orientation in the inclusion of activism in their role? Here, we find that the Rural social workers are <u>least</u> discrepant in their organizational and personal roles, while Inner City workers are much more discrepant. Interestingly, too, these rural social workers are the most homogeneous in their response.

Finally, we turn to the dimension of exclusion.

(Table 15)

To what extent are social workers characterized by geographic variations in the perception of organizational and personal domain? At first glance, the data in Table 15 suggest a uniformity of perception: no significant differences by geographic complexity. The very low perception of CMHC Exclusion of our Rural social workers (2.2) relative to their counterparts in other areas warranted closer inspection. T-tests of the mean for Rural

social workers against social workers in other settings were all significant.* In other words, we can assert that the Rural social worker is, indeed, different. The failure to find significant differences on the personal/professional side of the ledger suggests that the rural CMHC exerts a pervasive influence on perception of domain. This strengthens our findings as reported in Table 2.

Perhaps the best way to sum up the ways in which rural social workers are different from social workers practicing in other settings is to list the nature of the differences:

1) Community Mental Health Ideology: Inner City and Rural social workers most highly endorse this ideology.

2) Orientation of Center: Rural social workers, more than those in any other setting, view their CMHC as falling close to the social agency end of the organizational continuum.

3) CMHC Organization Activism: Rural social workers -- in contrast to others -- perceive their organizations as expecting greater activism in their roles.

4) Personal/Professional Activism: Inner City social workers are most activist in role definition. Rural workers occupy something of a modal position in activism.

5) CMHC Exclusion: Rural social workers perceive their CMHC's as expecting the fewest areas of community life to be excluded as appropriate arenas of intervention.

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*While t-tests of individual pairs might tend to exaggerate the relationship, the considerably lower level of exclusion manifested by social workers in Rural centers suggested that this was an appropriate analysis. The t-tests and levels of significance were: Rural-Inner City: -1.96, .05; Rural-Urban: -2.44, .02; Rural-Urban Mix: -2.92, .005; Rural-Rural Mix: -2.65, .01. None of the other comparisons even approached significance.

CONCLUSIONS

Although community mental health seems to have had its most vigorous and extensive application in urban and inner city America and, some say, was developed largely in response to these constituencies, it has found unique expression in the rural setting. Why? In the face of the demonstrated "health resources imbalance" and the less obvious -- but real -- "human services imbalance" which are exacerbated by the isolation and poverty of rural areas, the Community Mental Health Center has emerged as a unique and powerful resource. Unlike the Center in the urban setting, the rural Center has an almost uncontested opportunity to realize the intent of the community mental health movement as originally envisaged.

The proclivity of Rural CMHC staff in general, and social workers in particular, to view their organizations as most like social service agencies, underscores the fact that Rural CMHC's may be the only effective helping agency within a large catchment area. We might speculate that, rather than being bounded by "competing" agencies, creating pressures for the CMHC to remain within its walls, the Rural CMHC has the opportunity and ideological mandate to fill the vacuum.

The evidence is plentiful that social workers occupy a unique position among the helping professions. This general conclusion is augmented by the specific information that we have about the beliefs and role definitions that have been gathered about social workers as members of CMHC staffs. This leads to a curious dilemma for social workers. On the one hand, they do represent the "cutting edge" of community mental health in terms of its "ideal" ideology. On the other hand, the reluctance of CMHC's to actualize the community components of their programs, leads to clear indications of a discrepant situation in which their personal/professional proclivities are in strong contrast to their perception of their Center's

prescription of their professional behavior. It is likely, therefore, that it is both essential for social workers to be part of CMHC's and that social workers will find -- in these Centers -- a frustrating milieu for their community activities.

This potentially paradoxical and frustrating situation is not the case uniformly across all types of catchment areas. In Rural CMHC's, the social worker defines his or her professional role as most consonant with organizational expectations. Thus, here, the potential for frustration is demonstrably reduced. Further, the Community Mental Health Ideology of social workers in Rural CMHC's is most convergent with Indirect Services such as Program Oriented Consultation.

We cannot say whether social workers are selectively recruited to Rural CMHC's or whether they have an unusual voice in program development in these Centers, making them uniquely reflective of community mental health goals. Rural CMHC social workers do embody the social work ethic of community involvement and change to a greater extent than their peers in other geographic settings. The vital contribution of social workers to CMHC's finds particularly potent expression in the rural Centers. Here, social workers provide perspective and service to areas of maximum need.

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TABLE 1

ROLE ACTIVISM SCORES BY
GEOGRAPHIC COMPLEXITY OF CATCHMENT AREA

Geographic Complexity		CMHC Activism		Personal/Professional Activism		Activism Discrepancy	
		Mean	S	Mean	S	Mean	S
Inner City	(181)	38.90	9.62	48.76	9.52	-3.74	5.89
Urban	(48)	37.69	7.83	45.46	8.88	-3.58	4.38
Urban - Mix	(195)	37.16	8.35	43.44	9.10	-2.83	4.47
Rural - Mix	(116)	35.77	8.57	41.41	8.92	-2.58	4.85
Rural	(55)	40.18	5.57	44.25	7.31	-1.53	3.18
		$F = 3.72$ $P < .005$		$F = 6.91$ $P < .0001$		$F = 2.69$ $P < .05$	

TABLE 2

CMHC AND PERSONAL/PROFESSIONAL EXCLUSION SCORES
BY GEOGRAPHIC COMPLEXITY OF THE CATCHMENT AREA

Geographic Complexity	CMHC Exclusion		Personal/Professional Exclusion	
	Mean	S	Mean	S
Inner City (181)	4.65	5.18	1.79	3.25
Urban (48)	4.58	4.24	1.79	2.92
Urban - Mix (195)	4.74	4.78	2.31	3.92
Rural - Mix (116)	5.46	5.33	2.98	4.05
Rural (55)	2.46	2.66	1.42	2.23
	F = 3.67 P < .01		F = 2.86 P < .03	

TABLE 3

CMHI OF CMHC WORKERS BY GEOGRAPHIC COMPLEXITY
OF CATCHMENT AREA

Geographic Complexity	CMHI	
	Mean	S
Inner City (181)	213.5	29.88
Urban (48)	213.6	23.44
Urban - Mix (195)	212.4	29.07
Rural - Mix (116)	207.6	26.04
Rural (55)	218.4	22.72
	F = 1.60 P > 17	

TABLE 4

CMHC PERCEPTION OF CMHC WORKERS
BY GEOGRAPHIC COMPLEXITY OF CATCHMENT AREA

Geographic Complexity	CMHC Orientation	
	Mean	S
Inner City (181)	5.56	2.84
Urban (48)	5.15	2.63
Urban - Mix (195)	5.92	2.90
Rural - Mix (116)	5.28	2.48
Rural (55)	3.49	2.17
	F = 8.82 P < .0001	

TABLE 5

PROFESSIONALISM OF CMHC WORKERS
BY GEOGRAPHIC COMPLEXITY OF CATCHMENT AREA

Geographic Complexity	Professionalism					
	Client		Agency		Community	
	Mean	S	Mean	S	Mean	S
Inner City (181)	2.49	1.03	2.95	0.96	2.50	1.04
Urban (48)	2.63	0.82	3.10	0.83	2.77	0.81
Urban - Mix (195)	2.82	0.81	3.07	0.74	2.93	0.78
Rural - Mix (116)	2.81	0.88	3.04	0.91	3.03	0.85
Rural (55)	2.69	0.72	2.96	0.69	2.96	0.77
	F = 4.02 P < .005		F = 0.69 P > 60		F = 8.89 P < .0001	

TABLE 6

CMHI BY PROFESSIONAL AFFILIATION

Professional Affiliation		CMHI	
		Mean	S
Psychiatrist	(72)	194.8	31.05
Psychologist	(96)	218.8	23.20
Social Worker	(140)	220.9	26.39
Nurse	(96)	210.2	28.80
Educator, Counselor, Minister	(24)	223.3	20.17
Rehabilitation Worker	(35)	207.3	26.75
Non-Psychiatric Physician	(10)	204.5	35.13
Other	(27)	218.6	21.78
Paraprofessional	(95)	207.4	26.20
		F = 7.83 P < .0001	

TABLE 7

PERCEPTION OF OWN CMHC BY
PROFESSIONAL AFFILIATION

Professional Affiliation		CMHI	
		Mean	S
Psychiatrist	(72)	5.68	2.94
Psychologist	(96)	4.76	2.87
Social Worker	(140)	5.76	2.73
Nurse	(96)	5.68	2.84
Educator, Counselor, Minister	(24)	4.67	2.50
Rehabilitation Worker	(35)	5.37	2.57
Non-Psychiatric Physician	(10)	5.70	3.09
Other	(27)	4.19	2.24
Paraprofessional	(95)	5.52	2.82
		F = 2.03 P < .05	

TABLE 8

PROFESSIONALISM BY PROFESSIONAL AFFILIATION

Professional Affiliation	Arena					
	Client/ Profession		Agency/ Profession		Community/ Profession	
	Mean	S	Mean	S	Mean	S
Psychiatrist (72)	2.86	1.01	3.24	0.97	2.97	1.02
Psychologist (96)	2.84	0.85	3.22	0.77	2.88	0.85
Social Worker (140)	2.66	0.93	3.05	0.80	2.70	0.97
Nurse (96)	2.92	0.75	3.12	0.66	3.01	0.69
Minister, Educator, Counselor (24)	2.67	0.82	2.75	0.79	2.83	0.76
Rehabilitation Worker (35)	2.40	0.88	2.87	0.76	2.80	0.72
Non-Psychiatric Physician (10)	3.00	0.94	3.50	0.71	3.00	1.05
Other (27)	1.93	0.92	2.41	1.08	2.41	1.22
Paraprofes-sional (95)	2.52	0.81	2.77	0.89	2.65	0.88
	$F = 5.24$ $P < .0001$		$F = 5.34$ $P < .0001$		$F = 2.29$ $P < .02$	

TABLE 9

ROLE ACTIVISM SCORES BY PROFESSIONAL AFFILIATION

Professional Affiliation	CMHC Activism		Personal/Professional Activism		Activism Discrepancy	
	Mean	S	Mean	S	Mean	S
Psychiatrist (72)	37.47	7.78	40.32	8.46	-1.11	3.00
Psychologist (96)	37.78	7.98	44.35	8.28	-3.09	4.33
Social Worker (140)	36.81	8.67	45.46	9.45	-3.95	5.92
Nurse (96)	38.01	7.70	42.78	8.53	-2.10	3.98
Educator, Counselor, Minister (24)	40.83	7.32	47.67	8.01	-2.96	5.30
Rehabilitation Worker (35)	37.29	9.68	44.63	10.94	-3.51	6.28
Non-Psychiatric Physician (10)	41.60	8.68	43.40	9.08	-0.60	1.43
Other (27)	39.78	10.36	48.48	10.35	-3.93	5.19
Paraprofessional (95)	37.41	9.96	44.95	9.27	-3.62	5.08
	F = 1.08 P > 37		F = 3.58 P < .0008		F = 3.09 P < .002	

TABLE 10

CMHC AND PERSONAL/PROFESSIONAL EXCLUSION
BY PROFESSIONAL AFFILIATION

Professional Affiliation		CMHC Exclusion		Personal/Professional Exclusion	
		Mean	S	Mean	S
Psychiatrist	(72)	4.26	4.75	3.15	4.33
Psychologist	(96)	4.38	4.54	1.67	2.69
Social Worker	(140)	5.04	4.76	1.61	3.29
Nurse	(96)	4.32	4.75	2.74	3.96
Educator, Counselor, Minister	(24)	2.88	4.32	0.71	1.57
Rehabilitation Worker	(35)	5.00	5.55	2.26	3.49
Non-Psychiatric Physician	(10)	3.40	2.99	2.90	3.07
Other	(27)	4.11	5.06	1.00	1.80
Paraprofessional	(95)	5.43	5.47	2.70	4.19
		F = 1.11 P > 35		F = 2.89 P < .004	

TABLE 11

CMHI OF SOCIAL WORKERS
BY GEOGRAPHIC COMPLEXITY OF CATCHMENT AREA

Geographic Complexity	CMHI	
	Mean	S
Inner City (47)	228.9	21.14
Urban (9)	213.7	26.68
Urban - Mix (38)	215.8	31.14
Rural - Mix (29)	212.1	28.74
Rural (17)	228.9	15.28
	F = 2.97 P < .03	

TABLE 12

CMHC ORIENTATION OF SOCIAL WORKERS
BY GEOGRAPHIC COMPLEXITY OF CATCHMENT AREA

Geographic Complexity	CMHC Orientation	
	Mean	S
Inner City (47)	6.21	2.66
Urban (9)	5.22	2.11
Urban - Mix (38)	7.13	2.21
Rural - Mix (29)	5.03	2.80
Rural (17)	2.94	1.60
	F = 9.85 P < .0001	

TABLE 13

PROFESSIONALISM OF SOCIAL WORKERS BY
GEOGRAPHIC COMPLEXITY OF THE CATCHMENT AREA

Geographic Complexity		Arena					
		Client/ Profession		Agency/ Profession		Community/ Profession	
		Mean	S	Mean	S	Mean	S
Inner City	(47)	2.43	0.97	3.02	0.90	2.28	1.04
Urban	(9)	2.56	1.01	3.22	0.44	2.67	1.00
Urban - Mix	(38)	2.74	0.92	3.11	0.73	2.90	0.89
Rural - Mix	(29)	2.86	0.95	3.03	0.91	3.00	0.89
Rural	(17)	2.82	0.64	2.94	0.66	3.00	0.71
		F = 1.33 P > 26		F = .24 P > 91		F = 4.04 P < .004	

TABLE 14

ROLE ACTIVISM SCORES OF SOCIAL WORKERS
BY GEOGRAPHIC COMPLEXITY OF CATCHMENT AREA

Geographic Complexity	CMHC Activism		Personal/Professional Activism		Activism Discrepancy	
	Mean	S	Mean	S	Mean	S
Inner City (47)	38.83	10.04	48.64	10.50	-4.75	7.60
Urban (9)	33.89	6.75	46.67	8.89	-6.11	4.17
Urban - Mix (38)	34.58	6.92	42.13	8.37	-3.11	5.04
Rural - Mix (29)	34.62	8.51	43.69	9.23	-4.31	5.04
Rural (17)	41.47	6.56	46.53	6.62	-1.88	4.00
	F = 3.44 P < .01		F = 3.02 P < .02		F = 1.26 P > .28	

TABLE 15

CMHC AND PERSONAL/PROFESSIONAL EXCLUSION SCORES OF SOCIAL WORKERS BY GEOGRAPHIC COMPLEXITY OF CATCHMENT AREA

Geographic Complexity		CMHC Exclusion		Personal/Professional Exclusion	
		Mean	S	Mean	S
Inner City	(47)	4.9	5.13	1.1	2.54
Urban	(9)	5.8	4.06	1.1	1.96
Urban - Mix	(38)	5.6	4.24	2.4	4.29
Rural - Mix	(29)	6.0	5.34	1.9	3.79
Rural	(17)	2.2	3.23	0.9	1.58
		F = 2.06 P > .09		F = 1.23 P > .30	